Though this be method, yet there is madness in't: Commentary on O*ne Year Longitudinal Study of the Psychological Effects of Administrative Segregation*

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Abstract

This article examines some of the findings of a recent study of the psychological effects of administrative segregation (solitary confinement) on prisoners held at the Colorado State Penitentiary over a period of one year. While the study is a credible attempt to overcome many of the drawbacks that have prevented systematic studies of solitary confinement in the past, its design, methods, and statistical analysis suffer from problems that render its findings flawed, Accordingly, these findings should not be generalized.

Key words: administrative segregation, Colorado, human rights, mental health, supermax.

Debate on the effects of solitary confinement on body and mind is as old as the practice itself. Is solitary confinement harmful? How harmful? Is it more harmful for certain groups of prisoners? If it does not do any harm, does it do any good? Over the years, the consensus among researchers has largely been that solitary confinement is damaging to health and well-being, and that it also adversely affects prisoners' chances of successful reintegration into society. Every few years, a newly published study demonstrating few negative effects (e.g., Zinger & Wichmann, 1999), or negative effects that diminished rapidly once the prisoner was removed from segregation (e.g. Anderson at al., 2003), regenerates the debate. Now a new Colorado study (O'Keefe et al., 2010) goes a step further in suggesting that its findings demonstrate that segregation did not lead to an increase in adverse psychological symptoms in most prisoners. The study also reports that, where a significant change could be observed, it was mostly a positive one (i.e. improved mental health). It is entirely predictable, then, that its findings have generated some impassioned responses.

Colorado study

The Colorado study purports to be the product of a robust and careful methodology that, according to its authors, distinguishes it from most other studies of the effects of solitary confinement. Where they are mentioned at all, studies that revealed a different picture to that painted by the Colorado study are dismissed on the grounds of being methodologically weak. There are indeed a number of methodological and ethical issues which make it difficult to systematically assess the effects of solitary confinement over time. For a start, gaining access to isolated prisoners is difficult, especially over a period of time. Furthermore many factors contribute to how prisoners experience their confinement and how they are affected by it, including:

- the physical conditions of confinement;
- level and form of contact with the outside world;
- in-cell provisions;
- access to programs and activities;
- medical and mental health treatment;
- staff-prisoner relationships, and
- the ethos and atmosphere in the prison.

These factors will all impact on the prisoners' experience of solitary confinement, making it near impossible to control for all potential variables and limiting the ability to generalize any findings. These difficulties are compounded by the fact that reliable information about prisoners' medical history is not always available to researchers, making it difficult to make accurate assessments of mental health and pre-morbid adjustment. Further issues arise from the simple fact that interaction with researchers offers isolated prisoners a break from the monotony of their confinement and may in itself impact on outcomes. It may also be the case that participation in a study provides prisoners with a sense of purpose which they normally lack in prolonged solitary confinement. When the Colorado study was carried out, National Geographic were filming a documentary at the Colorado State Prison (CSP), which meant that there was significantly more activity than usual for segregated environments.

This study is a credible attempt to overcome many of the drawbacks that have prevented systematic studies of solitary confinement in the past. It was headed by a Colorado Department of Corrections (CDOC) employee enabling full access to prisoners, staff, and prisoner records at regular intervals over the course of more than a year. The study report is clearly written and, at first appearance, comprehensive. Yet, the authors are not entirely forthcoming in providing a full account of the use of administrative segregation (AS) in Colorado, their most restrictive custody level (generically known as "supermax" confinement). In particular, the report fails to mention that at the time the study was conducted, the CDOC was involved in a bitter budgetary struggle lasting several years to gain funds to open the newly-built CSP II, a prison facility with a total capacity of 948 AS beds (see CDOC Budget Hearing, January 2010).

In March 2010, Colorado's legislature finally approved funds to enable CDOC to staff and open the first of three CSP II towers, providing the CDOC with 316 additional AS beds as of September 2010 (Colorado General Assembly, 2010). When the entire CSP II facility becomes operational, it will substantially increase the number of segregation beds in a state which already isolates a much higher proportion of its prisoners than the national average. In 2000 an estimated 7.5% of Colorado's prisoners were held in administrative segregation, compared to a national average of 3.3% (CCJRC, 2010). This sort of information is relevant to understanding the scale of use of solitary confinement in Colorado, as well as the political context of the study.

We agree with the criticism directed at the authors of the study (e.g., Grassian, 2010; Casella, 2010) concerning the reliance on psychometric data alone. Considering the potentially devastating effects of segregated confinement and the possible wider repercussions of these research findings for other jurisdictions, the choice of relying exclusively on self-reports, in the absence of assessments carried out by trained clinicians and other behavioral data, is regrettable. We also believe that many of the subjects were likely to already have been damaged by their custodial experiences before the study began so that the impact of the period of solitary confinement under scrutiny in the study may well have been attenuated. Furthermore, we think that the study is undermined by the lack of focus on post-release outcomes and the long-term impact of sustained solitary confinement on reintegration into society. In other words, the study does not tell the story of solitary confinement for study participants from the beginning, nor does it tell the story through to the end. But most importantly we have serious concerns that the statistical analysis of unreliable self-report data may have resulted in spurious findings.

Troubling methods

The initial problem with the research design is that the participants had an extensive previous history of incarceration, and those placed in administrative segregation had a greater segregation history than those who were placed in general population. We are told that prior to their AS hearing all prisoners were segregated, typically for around three months. To ensure that this did not influence findings, researchers took a "pre-baseline" measurement of the CSP groups "as close to the AS hearing as possible" (O'Keefe et al., 2010, p. 19). But at this point subjects had already experienced up to three months in segregation. Thus, although the study was longitudinal it started at a point in an ongoing cycle of offending and incarceration that would already have impacted on the subjects of the study before it began**.**

Second, prisoners with learning difficulties and/or a reading age of less than 8th grade were excluded as they would have struggled to complete the self-report psychometrics. This resulted in an over-representation of participants with a high school diploma or an equivalent qualification (Table 3): 63% in the CSP Mentally Ill (MI) sample and as many as 69% in the CSP Non Mentally Ill (NMI) sample. This will have significantly skewed the sample, as the literature shows that prisoners with learning difficulties are usually over-represented in segregated housing and are the least well-equipped to cope with isolation.

Third, the CSP operates a system of incentive-based programming, which involves the prisoner working his way through three levels, each associated with increased privileges (TV, telephone calls, hobby and craft

materials, canteen allowance, and so on). We are not told which level of programming prisoners were at during each testing period and this variable is not controlled for in the study, despite the possibility that it may have accounted for the apparent improvement over time. For prisoners with very little to start with, breaks in the routine and small improvements in quality of life are hugely important. Where a prisoner is held for 23 hours a day in a small sparsely furnished cell with little to do, having access to a television or having more contact with family and friends can dramatically improve well-being. It is entirely possible that mental health "improvements" observed over time could be attributed to the prisoner's advance through the system of increased privileges rather than any alleged benefits of solitary confinement. In fact, we are told that many of the institutional indicators that may have validated the claim that individuals improved in well-being over time were not collected reliably enough to be used in the analysis. The information concerning incentive levels, time out of cell for showers, exercise, and use of the phone, as well as the behavior ratings of custodial staff and mental health professionals, was all excluded from the analysis because they were incomplete.

Fourth, the attempt to establish the validity of participants' self-report by means of the SIMS that screens for feigned symptoms in a clinical or forensic setting provides some very important findings. We are told that most of the participants (85%) had an elevated score on at least one of the five subscales of affective disorders, neurological impairment, psychosis, low intelligence, or amnesic disorder (O'Keefe et al., 2010, p. 35). In fact, Table 7 indicates that between one-half and two-thirds of the whole sample returned an inconsistent profile on each scale. Moreover, there is a distinct and significant pattern to participants' responding by group (with a chi square of $p<.001$) with the mentally ill returning a much more inconsistent profile than the non-mentally ill and the segregated sample returning a more inconsistent profile than the general population sample. We are then told that scores above the cut-off may actually reflect genuine psychopathology as well as malingering. The authors propose that as the pattern observed in their study may thus reflect genuine psychopathology, no one was excluded on the basis of their SIMS scores. Indeed, doing so would have eliminated the majority of the sample and have proved fatal to the entire study.

This finding not only confirms the already damaged nature of the population under study and the essential unreliability of their self-report data, but it also implies a very high error of measurement in the scales used in the analysis, which brings us to our final point. A method of data analysis that compares mean scores over time is hugely susceptible to the statistical distortion of regression to the mean, the more so the greater the error of measurement of the tests used. It is to be expected that initial high or low aggregated scores will move closer to the population average over time, and that this is an artifact of measurement rather than a real shift in experience. As the most disturbed groups returned the most extreme scores on the initial measures of well-being, they would have been the most susceptible to this effect. The fact that the effect is also evident in the general population control group adds weight to our conclusion that this may be a statistical phenomenon rather than a real improvement in adjustment. In short, it is likely, in our opinion, that the finding of apparent improvement over time, greater in the more disturbed group, is essentially a statistical artifact. This constitutes a huge problem for the Colorado study.

Conclusion

Beyond any methodological criticisms of the Colorado study, there remains one key, much wider problem. Solitary confinement is not a natural state for us as social creatures who require human contact and human touch to maintain our very sense of "self." It is difficult to see how prison systems which officially aim to rehabilitate offenders and assist their reintegration into society propose to provide prisoners with the social skills and tools necessary for living alongside others by withholding social contact. In many supermaxes prisoners spend many years and in some cases even decades in conditions of extreme solitary confinement. It is possible that some of the deeper and longer lasting deficits that result from solitary confinement only reveal themselves once the prisoner is exposed again to the real world. Certainly interviews with former prisoners who have spent long stretches of time in solitary confinement suggest that the pains of isolation remained with them long after their release and that those who did not manifest serious mental illness were nonetheless deeply scared by the experience (Shalev, 2009). In this context, the finding that withdrawal/alienation increased over time in the segregated group is worrying in terms of potential impact on rehabilitation and resettlement.

It would be tragic indeed if departments of corrections decided to invest in further supermax facilities on the basis of a flawed study. There is also a real risk that the Colorado study will be used to justify the warehousing of large numbers of mentally ill prisoners in solitary confinement. In Colorado alone, over a fourth of AS prisoners have been classified as mentally ill. Rather than isolating an increasing number of prisoners, many of whom are mentally ill, the CDOC- and similarly other DOCs- would be well advised to reconsider their policies regarding AS placement with the overall aim of reducing the use of segregation and diverting more funds to increasing and improving mental health and program provisions in prisons.

In all cases, where prisoners are placed in solitary confinement, for whatever reason, prison authorities should put in place established safeguards to ensure that prisoners are always treated with respect for their inherent human dignity (Shalev, 2008). Rather than maintaining complete separation between prisoners and staff, as is the case in many supermax facilities, more emphasis should be placed on increased and sympathetic contact with prisoners. Treating prisoners well, particularly those who are challenging and difficult to manage, is at the very least a legal requirement, but experience from other jurisdictions shows that it also makes operational sense and can help to mitigate the negative effects of confinement as well prisoners' prospects of a successful reintegration to free society on release.

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